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Developing excellent leaders - the role of Executive Coaching for GP specialty trainees

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Developing excellent leaders- the role of Executive Coaching for GP specialty trainees.

Abstract:

Introduction

Given an increasingly complex healthcare environment, doctors need to rise to the challenges of leadership. Executive coaching offers innovative and workable means of realising excellence in leadership. Coaching creates an empowering, ‘high challenge, high support’ environment for significant growth. This study sought to determine general practice (GP) specialty trainee (ST3) knowledge of coaching, views on leadership training, and reflections on the experience of receiving coaching.

Methods

All GP ST3s in one UK region completed a questionnaire about coaching and developing leadership abilities. Six received professional coaching sessions, followed by a semi-structured interview.

Results

Baseline knowledge of coaching was sparse. Trainees felt under-equipped for leadership, but were keen to develop themselves.

The short intervention appeared to result in a shift in leadership mind-set in four key areas: courage, passion, impact, and vision. A new enthusiasm was apparent, as well as a willingness and desire to increase leadership responsibilities.

Conclusion

This is the first UK study examining professional executive face-to-face coaching as an educational method for doctors. Coaching helps provide leadership ‘language’ and ‘identity’. It appears to ‘name’ clients as ‘leaders’ and challenges ‘imposter

phenomenon'. Coaching provided bespoke, deep, experiential learning, with transferable benefits not otherwise available in the Specialty Training programme.

Keywords

Postgraduate, executive coaching, specialty trainee, General Practice, leadership.

Practice Points

- Developing excellent leaders is vital for general practice
- Executive coaching improves effectiveness and leadership skills within other professional sectors
- Executive coaching is well received by GP trainees, and provides experiential benefits not otherwise available in specialty training
- Trainees were positive about having a non-medical coach
- Coaching helps provide leadership 'language' and 'identity', and challenges 'imposter phenomenon'.

Table 1 (Ideal location- on the first page, near the start of the article)

Definitions:
<ul style="list-style-type: none">• Coaching is a collaborative solution-focused, results-orientated and systematic process in which the coach facilitates the enhancement of work performance, life experience, self-directed learning and personal growth of the coachee [1].• Coaches are equals rather than advice-giving experts. They believe the client to be the best person to solve their individual problems in their own way. A coach creates a safe, empowering, ‘high-challenge, high support’ environment where it is possible to provide immediate and detailed personal feedback. Coaching is about change and action [2].• ‘Executive Coaching’ specifically targets senior management, linking strongly to organisation benefits, vision, and producing results.

Introduction

Doctors need excellent leadership skills now more than ever, and it has been suggested that coaching could provide a means for developing excellence in leadership abilities [3-5].

The future of the profession depends upon doctors being equipped to lead with excellence [6]. There is evidence that better leadership results in improved patient care, reduced patient mortality [7], financial savings [8], lower rates of patient complaints [9], and the creation of effective multidisciplinary teams [10,11].

Meanwhile, doctors are experiencing increased rates of burnout, stress-induced emotional and mental illness, and addiction to drugs and alcohol [12]. Improving personal resilience is therefore a matter of critical importance to maintain a healthy workforce.

How prepared are doctors for leadership roles? It is argued that on completion of training they do not have the experience or confidence required to take on clinical leadership roles [13] while if coaching were a cultural norm in the NHS, benefits could accrue including increased trainee satisfaction, improved morale, reduced absence and clear vision for the future [3]. The NHS Leadership Academy affirms coaching as a key approach to develop leadership within organisations. ‘Coaching is a method of developing an individual’s capabilities to facilitate the achievement of organisational success’ [5].

The coaching industry is well established within other professional sectors such as business, sports and politics, with global revenue of almost \$2 billion [14]. Could a similar commitment in health care result in real benefits?

Three meta-analyses provide an evidence base for coaching efficacy outside of healthcare [15-17]. ‘The First 500’ report evaluated 500 doctors and dentists who participated in the opening two years of a bespoke service in the London deanery [18]. Several UK studies have shown varied benefits of coaching including: increased confidence chairing meetings, strategic thinking, interpersonal relationships and conflict management [19]; self-change, self-development, and self-reflection [20]; increased awareness, improved attitude, adapting a new mind-set, and an increased enjoyment of work [21]. The NHS England Coaching Pilot of GPs studied doctors who were actively considering leaving or had recently returned to the profession after a break, by asking them to rate their likelihood of leaving the profession both before and after coaching – the results^[1]_[SEP] suggested that it had, in all probability, reduced the incidence of loss to the profession [22]. An Australian study of rural GPs also demonstrated the use of coaching to reduce stress levels and reduce their desire to leave rural general practice [23].

There have been no studies examining the use of non-medical professional executive coaches conducting face-to-face coaching with GPs trainees.

Methods

All final year general practice trainees (GP ST3s) in Northern Ireland (n=46) were invited to complete a questionnaire anonymously at a 'core' training day. This asked about: trainee current leadership roles, perceived importance of developing leadership skills, and assessment of the current local knowledge of coaching for patients and doctors.

Respondents could leave a contact phone number if interested in receiving six sessions of coaching free of charge. Those whose questionnaire responses suggested a high degree of engagement or interest in leadership activity were purposefully sampled for the intervention.

Each trainee was offered six coaching sessions (60 - 90 minutes) within a 12 week period. Coaches were selected based on qualifications and experience. Each had appropriate advanced coaching qualifications, was a member of a recognised regulatory organisation, had worked to achieve a minimum of five years experience in executive coaching, or was deemed as being active at a high standard by their network of peers.

Trainee/coach matching was based on time, availability and location. Details of sessions were non-directive, and entirely at the discretion of trainee and coach.

Content was trainee centred, with the coach following whatever direction the trainee felt would have most meaning. However, coaches were encouraged to maintain an

‘executive focus’ – the purpose being to develop the leadership capability of the trainee.

Within 2 weeks of the end of coaching all (except one who had a delay of five weeks due to personal circumstances) took part in semi-structured interviews conducted by SH - a male GP and executive coach, who did not provide any coaching for the study.

Participants were asked about the experience, attitudes about leadership/ management roles, and reflections on coaching for education of doctors or patients. The interviews were audio-recorded and lasted up to one hour. Field notes were kept.

Transcription and preliminary analysis of content was conducted after each interview and any new concepts fed into subsequent interviews in an iterative fashion. SH and KMcG independently coded the first two transcripts. Subsequent discussion about content and how it was coded allowed the development of a coding frame which then facilitated coding by SH of the remaining four interviews. Paper based methods were used to facilitate familiarisation with and immersion in the data, and allowed distillation of the content into major themes. Although the number of interviews conducted had to be a pragmatic choice, the lack of new themes or concepts being discerned by the penultimate interview suggested data sufficiency. To ensure accuracy of content trainees were sent their interview transcripts, followed by a five-ten minute telephone interview with SH.

Results

Pre-coaching questionnaire

All 46 specialty trainees (ST3) present at a core training day completed the pre-coaching questionnaire (14 males and 32 females).

Of the 46, four felt well equipped to occupy an elected position in a medical leadership/management organisation (e.g. BMA/ RCGP). Five currently performed such a role, but only two intended to apply for such a position in the next year.

Twenty-one said they would appreciate further opportunities to develop skills of leadership and management within the GP Specialty Training scheme.

Four trainees knew how to access coaching schemes for leadership development, but none had ever considered consulting a personal coach.

Intervention group - Interview data

Thirteen trainees responded positively to the offer of coaching. The six selected for participation comprised four females and two males. Three trainees completed all 6 sessions but two had 5, and one had 4 (within the 12 week period).

The themes identified were organised under three headings:

- General experience of coaching
- Leadership identity
- Areas of leadership development

General experience of coaching

Participants all expressed gratitude for the experience. They became more aware of personal strengths, identified barriers to goals, and considered how to make appropriate alterations. They became aware of the effects of their own unhelpful traits and were comfortable to talk about these. For example, identifying negativity, the tendency to be ‘people-pleasing’, lack of self-confidence, low self-esteem and inhibiting fears:

“Now I can pick up quicker when I feel like I’m trying to control something. Em... so I think in the past, maybe I was controlling but I wasn’t aware of it... whereas now I’ve got self-awareness of what I’m doing and why I’m doing it.” [Interview 1, female].

Coaching provided benefits not otherwise available in training:

“There is that gap in the curriculum, and doctors, well especially GPs, are going to be in management type roles, and it’s very helpful (coaching) because there’s no undergraduate... focus on that... there are things that can be learnt that aren’t taught throughout the undergraduate curriculum, and certainly in the specialty training too.” [Interview 6, female].

Respondents saw potential for adopting a coaching style in their consulting; patients presenting with work-life balance issues, stress, weight problems, smoking, sick-lines, inappropriate requests, and confidence when speaking with more senior colleagues. Attitudes towards patients had changed - they were exhibiting a more motivating and

non-judgemental presence with a deeper emphasis on empowering patients, asking new questions to explore patient values or to create novel self-awareness.

Respondents felt coaches without medical backgrounds brought beneficial external perspectives but commented that six sessions in 12 weeks made for an intense experience, and a longer period would be preferable.

Leadership identity

Several stated that they hadn't previously recognised themselves as 'leaders':

"She (the coach) challenged what I thought about being a leader. I told her I didn't have leadership skills, I felt I wasn't a leader." [Interview 4, female]

A prior underlying lack of worthiness and confidence in competency as a leader was thoroughly challenged by strength identification, reframing, and self-compassion. Trainees seemed to grow in self-worth, self-efficacy, conviction, and independent thought. Identification of underlying abilities and recognition of transferable skills saw trainees report a fresh confidence and sense of inner belief regarding their capabilities:

"Coaching has made me identify where I was being a leader within the practice. I hadn't really thought that was a leadership skill – I just thought that was something I have, something you offer.... " [Interview 1, female].

“I do have direction, and I do have aspirations and know where I want to be, and she (the coach) said, ‘Yes you are a leader’, and I had never thought of myself in that way at all.” [Interview 4, female participant].

All reported a new enthusiasm, willingness and desire to increase leadership responsibilities in the future. New interests included becoming an educator and engaging with quality improvement activity:

“I think I look for opportunities now to show that I’m a leader, in a way, and I’m more confident in terms of trying to lead patients.” [Interview 4, female participant].

Areas of leadership development

The trainees reported clear shifts in thinking or changes to behaviour in four key areas of leadership: courage, passion, impact and vision.

1) ‘I’m leading with more... courage’

Areas requiring attention were recognised: a tendency to be risk averse; fear about career opportunities; timidity with staff; requiring excessive validation from others, and perfectionism leading to over burdening oneself. Trainees frequently indicated that by growing in confidence and recognising their abilities, they were acting in a more courageous manner. For example, being more comfortable in delegating, decision-making, confrontation/conflict management and appropriate assertiveness:

“I’m better at standing up for myself now in terms of... you know in those interactions with for example, the consultant that was on the phone earlier on... I

would have felt hugely panicked in that, sort of, confrontation, in a way before, but now I feel like... ‘No, I’m making this decision... ’ [Interview 4, female].

The clinical decision-making process also featured prominently including challenging overly cautious or defensive approaches. There was evidence of increasing confidence in conflict management:

“I’m certainly getting better at saying no to things, like inappropriate sleeping tablet requests, and inappropriate pain killer requests and things like that...I’m just saying, ‘I’m not comfortable with doing that, and these are the reasons why’, and so far people have been, like, ‘I accept that, that’s fine.’ It was just having the guts to try doing that first.” [Interview 4, female].

2) ‘I’m leading with more... passion’

‘Passion’ reflects elements of a strong emotional response that engenders a compelling drive to action. Factors in improvement of engagement and morale at work included becoming more aware of tendencies to passivity and actively challenging issues rather than turning to escapism and distractions:

“By looking at and identifying frustrations I can almost alleviate them – that was really a big thing... I think it improves self-motivation, I think it improves your own morale, and improves your work” [Interview 1, female participant].

Respondents grew in positivity and self-compassion, learning to balance harsh self-criticism. Fairly recognising strengths and accomplishments, and becoming aware of positive emotions led to experiencing more ease and joy in work encounters.

Trainees appear to have learnt how to view their working lives more creatively, adopting a new experimental attitude to tasks:

“Having that experience just made me think, ok, a wee bit broader, and maybe that there’s other techniques that I could explore.” [Interview 4, female].

Another reason for increased engagement was the reduction of stress levels - a major benefit that was frequently reported by trainees:

“There’s lots of high stress at the moment isn’t there? Amongst GPs, with, sort of, work pressure, and I think I certainly, I remember the first few weeks before, or maybe two weeks later (after starting coaching), and I was just so much more relaxed, two weeks afterwards, from getting work done and sorted.” [Interview 5, male].

The coaching skill of ‘reframing’ problems in order to see them from a different perspective also appears to have led to an increased sense of ease with the challenges of work:

“(my trainer) moved me from 15 to 10 minute appointments without any notice, so I came in one morning, logged onto the computer and saw that this had happened, and before the coaching I would have just panicked and thought, ‘Holy Moly, I’m not

going to cope, this is going to be dreadful, this is going to be a nightmare,’ and my instant reaction within seconds, was a bit of excitement! I saw this and thought, ‘Why am I excited?! What?! That’s weird! Why would I react that way?’ And then I realised that this was this huge hurdle in my mind that I didn’t think I was going to get over, and that morning I was going to get an opportunity to have a go... ‘That is not how I would have reacted even a handful of weeks ago.’ [Interview 4, female].

3. 'I'm leading with more... impact'

A very popular topic with trainees was how to improve organisational skills. This includes time management, efficiency, effectiveness, procrastination, action planning, and proactivity. Trainees reported challenging these issues by experimenting with a personal action plan and using the accountability of the coach relationship to maintain momentum as they discussed progress. Examples included specific changes around both working and family life:

"I think it (coaching) has improved my time management on the whole, and it increased productivity within the working day... the realisation that... my current methods of working would be unsustainable to go forward to such a role." [Interview 3, male].

4. 'I'm leading with more... vision'

Respondents demonstrated growth in their personal and professional lives by building on their sense of vision for what they wanted in the present and future. There appears to have been a fresh understanding of personal values, with a sense that respondents had thought through the person they wanted to be, how they affect those around them, and how they could be intentionally influential (aspects of emotional intelligence). In doing so, they exhibited signs of noticing the effects of where their life didn't match these values, and then made efforts to re-align actions accordingly. Trainees reported ripples of 'coach-like' behaviour impacting on their families, patients, colleagues and working environment. They took note of their current work culture and began to

visualise what culture they would want to create themselves – a key component in the initiation of change:

“Teamwork and communication and having respect for others and, you know, hopefully them having respect for me. These values... were important to me, and if I was going to be a partner what could I do in the future to make sure that happens in the practice that I’m involved in. Communication, team working, and then having a value for... well especially the admin staff... showing your gratitude to somebody as well... Simple things that would, you know, boost the morale in the place and help the running of the practice, a wee bit.” [Interview 2, female].

Trainees appreciated being encouraged to focus on what they wanted to achieve, often with 5 or 10 year plans. For one trainee there was an emphasis on preparing for a job interview, while for others the focus was on organisational skills for working as a locum and partnership issues:

“I started to see it as an investment in my future self... this is what I am doing to make myself more confident, more resilient, more efficient for the future, and it’s worth me putting this time and effort in now – it’ll stand me in good stead for the career.” [Interview 4, female].

Discussion

Our findings suggest that near the end of specialty training these ST3s generally felt under-equipped in areas of leadership and management. They expressed a need for an alternative type of learning that is difficult to otherwise address in the curriculum.

There was little prior knowledge of coaching but those who experienced it in this study affirmed its utility to GP trainees. They recognised previously highlighted benefits of coaching: the inspiring effects of metacognition (thinking about thinking), a meaningful reflective process of self-awareness, the personalised approach, the acceptability of coaching techniques, and the power of supportive accountability that occurs in a coaching relationship.

Clear shifts in thinking and behaviour were evident in four key areas of leadership: courage, passion, impact and vision. Essentially, these relate to developing the heart and backbone of a leader. The following behaviours were shown to be amenable to coaching: appropriate assertiveness, challenging perfectionism, reducing the need for validation from others, challenging defensive medical decision-making, trusting clinical instincts, improving time management at work, and reframing of challenges in order to grow in resilience.

Crucially coaching can address leadership identity. Trainees may be subject to ‘imposter phenomenon’ [24]. Although making regular lifesaving clinical decisions, they somehow do not sense they are leaders. For example, not equating skills of breaking bad news with handling staff conflict. This study suggests there may be an even deeper issue of leadership identity than previously suggested [25]. Experiencing coaching enabled the trainees to develop a sense of self-efficacy, self-esteem, and self-confidence, agreeing with a previous key study of doctor leadership development [4]. A more telling benefit, not previously documented, is that coaching appears to ‘name’ trainees as leaders, giving them leadership ‘language’ for their behaviours.

The evident new enthusiasm makes a powerful statement about coaching's capability of unearthing leadership potential.

Participants demonstrated an increased awareness of their working culture, and began to visualise the GP practices they would want to create themselves, identifying their values and being proactive to align their plans with these. The emotional aspect of engagement (referred to as 'passion' in this study), is a strong driver of behaviour, and there appears to be a tendency amongst the medical profession to deny the potential impact of harnessing this for the common benefit.

Strengths and limitations

It is remarkable that six coaches were willing to provide sessions without payment. Our purpose was not to perform a trial of coaching, not to distinguish between types of trainees who could benefit from coaching. The views reported are the opinions of those who participated. Although this brings a bias, it does not negate the opinions of those who have given feedback. Of course, there may be a demand bias, where exaggeration of benefits occurs because expectations are formed that goals ought to have been reached when participating in a study. It could be argued that having a GP who is also a coach conducting the interviews may also have added an element of bias, but every effort was made to remind the trainees that it would be most helpful to uncover the broadest range of positive and negative comments.

Iterative analysis allowed extracted themes to be incorporated into subsequent interviews.

The ST3 year group was appropriate as they experience the stress of working in a general practice setting, exam pressures and also career transition, when the need for

leadership skills is readily apparent. Purposeful sampling for coaching selection was carried out because cross-sector research has shown coaching interventions are most effective in clients who are highly motivated with an interest in personal development [26,27]. From one perspective this selection process could be seen as a limitation, because findings would not be generalisable to other trainees who perhaps do not share the same current enthusiasm for leadership. However, in currently operating UK schemes in which doctors are coached the process tends to begin with self-selection by the doctor, and it is anticipated that developing schemes would also likely operate this way.

Comparison with existing literature

The intervention differed from previous research in four ways: participants were all GP ST3 trainees, coaching was conducted over a short period of time, none of the coaches had medical backgrounds, and coaching was conducted entirely face-to-face.

Six sessions over an 8-12 week period allowed for a more intense programme compared with the London Deanery [18], which employed 4 sessions over 6 months. The only criticism voiced by the trainees was they sometimes felt the period between sessions was too short. It seemed to produce an intense feeling in participants, which was spoken of both positively and negatively. They were making quite significant shifts in thinking and behaviour without always having adequate time between sessions to put their learning into practice.

The use of non-medical professional coaches in this context is unique. The London Deanery study utilised doctor coaches [18]. An external coach provides a healthy

challenge to the institutional blindness that can often be prominent in the medical profession. A non-medical coach will avoid the temptation of entering into a therapeutic relationship with the client, but may not have the advantage of providing medical networking opportunities, which a medical coach may be able to offer. One respondent said at times it would have been appreciated if they could have discussed more clinical matters. While there are clearly positives and negatives to be found in the background of any coach, it is ultimately their coaching skills and experience that will influence the coaching relationship, and thus the outcomes of the process.

Implications for research and/or practice

Multiple approaches are available for developing leaders, from generic skills sessions to the use of formal leadership training programmes. Any such processes need to be personalised, relating to individuals in the context of the system in which they are found, and ultimately conducted for the benefit of patients. Engagement that occurs on a predominantly intellectual level will not create the same commitment and energy as one that ascertains a trainee's own vision and passions.

Further research is needed to develop the evidence base for coaching. Proving return on investment and using RCTs are not straight-forward in this type of study, but projects with prolonged follow up or '360 degree' appraisal could provide further objective evidence.

Conclusion

Our study illustrates the potential executive coaching has to enhance the education of doctors, particularly with regard to leadership and management development.

Trainees found it engaging, applicable and relevant - a safe but challenging process

that provided experiential and transferable learning. They began to identify themselves as leaders, opening up the opportunity to explore what that might mean for them. The outcome was a fresh, proactive enthusiasm, and a desire to increase leadership responsibilities in the future. The implication is an exciting step forward in the pursuit of developing doctors who are ready to lead with excellence.

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Declaration of Interest

Dr Harte is an executive leadership coach. The study was approved by the Joint Research Ethics Committee at Queens University Belfast School of Medicine, Dentistry and Biomedical Sciences (Ref 15.08). No funding assistance was received.

Notes on Contributors

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